Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Renaissance Hospital 2929 S. Hampton Rd. Dallas, TX 75261	MFDR Tracking #: M4-07-1387-01 DWC Claim #: [redacted] Injured Employe[redacted]
Respondent Name and Box #: Dallas ISD Box # 42	Date of Injury: [redacted] Employer Name[redacted] Insurance Carrie[redacted]

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SEP 17 2007
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Carrier did not reimburse at usual & customary. Hospital is requesting to be reimbursed at usual & customary. Carrier denied request for reconsideration."

Principle Documentation:

1. DWC 60 package
2. UB-92(s)
3. EOB(s)
4. Invoices
5. Amount Sought $60,970.69

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

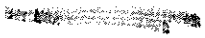
Respondent's Position Summary: "No additional allowance is recommended at this time. According to the discharge summary by Dr. Ozanne the claimant underwent the surgical procedure without complications. The claimant did progress slowly due to elevated fever and congestion. However, the charges for antibiotics and respiratory treatments did not justify 'unusually extensive services' as outlined in the 02/17/05 DWC staff report."

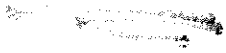
Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11-14-05 thru 11-17-05	W4, 97, W3	Inpatient Hospitalization	$60,970.69	$395.60
Total Due:				$395.60





PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason code "W4-No additional reimbursement allowed after review of appeal reconsideration; W3-Additional payment made on appeal reconsideration; and 97-Payment is included in the allowance for another service procedure."

2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually extensive services." Therefore, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services" or "unusually costly services."

3. Based upon the operative report, the claimant underwent anterior cervical diskectomy and foraminotomy at C3-4 and C4-5, anterior interbody fusion at C3-4 and C4-5; and anterior cervical instrumentation at C3-4 and C4-5.

4. The discharge summary report indicates that claimant's surgery was "without complications." The report indicates that claimant's progress post-operatively was slow due to elevated fever, increased congestion and phlegm.

5. Due to item #4 above and after reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved unusually extensive services with the amount of services and supplies for the post-operative period. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

6. The total length of stay for this admission was 3 days (consisting of 3 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $3,354.00 (3 times $1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

   The Requestor billed $27,673.00 for the implantables and supplies. The insurance carrier paid $6,376.70 for these charges. Cost invoices support charges of $7,173.00. Rule 134.401(c)(4)(A) allows for reimbursement to be cost + 10% for implantables, resulting in a reimbursement for implantables of $7,890.30.

7. The charge for surgical admission of $3,354.00 + $7,890.30 for implantables = $11,244.30.

8. The insurance carrier paid $10,848.70 for the inpatient hospitalization. The difference between amount due and paid = $395.60.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, the Division finds that additional reimbursement of $395.60 is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.401
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $395.60 plus accrued interest, due within 30 days of receipt of this Order.

DECISION:	[redacted]	9-14-07
	Elizabeth Pickle, RHIA	
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.